

10633 CERTIFICATE OF DEATH

Reg. Dist. No. 10639 51

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Calvert</i>
CITY (If outside corporate limits, write OR and give nearest town) <i>Jewell</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Jewell</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Doris</i>	(Middle)	(Last) <i>Brooks</i>	(Month) <i>11</i> (Day) <i>14</i> (Year) <i>1955</i>
5. SEX: <i>7</i>	6. COLOR OR RACE: <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>S</i>	8. DATE OF BIRTH: <i>9/22/55</i>
9. AGE last birthday: <i>8</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Dorsey Brooks</i>		14. MOTHER'S MAIDEN NAME: <i>Adelaide Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <i>Mother</i>			
18. MEDICAL CERTIFICATION			
a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
<i>772.0</i>			
Immediate cause		(a) <i>Malnutrition</i>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(b) <i>Has not been seen since it left Hospital</i>	
(c) <i>Volley but shind loves</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
SUICIDE		(CITY OR TOWN)	
HOMICIDE		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED	
m.		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>19</i> to <i>19</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>530 Ave</i> from the causes and on the date stated above.			
SIGNATURE <i>A. W. Ward</i>		DATE SIGNED <i>11/15/55</i>	
(Degree or title)		ADDRESS <i>Ches. Beach Md</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <i>11/15/55</i>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <i>11/15/55</i>		REGISTRAR'S SIGNATURE <i>A. W. Ward</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>Ches. Beach</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10083 10083

RECEIVED

NOV 29 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10634				10640			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 5-1							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
X TOWN <u>None</u>				TOWN <u>None</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Sharon</u>		(Middle) <u>Brown</u>		(Last) <u>Brown</u>		(Date) <u>11</u> (Month) <u>20</u> (Day) <u>19</u> (Year) <u>55</u>	
(Type or Print) <u>Sharon</u>							
5. SEX: <u>7</u>		6. COLOR OR RACE: <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>3/24/55</u>		8. DATE OF BIRTH: <u>9</u> (Month) <u>20</u> (Day) <u>19</u> (Year) <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Bernard Brown</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Harrod</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Wayne Bush</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>491X</u> <u>Pneumonia Bronchitis</u>							
DUE TO							
Antecedent cause(s) (h) <u>giving rise to the above cause</u> DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Died suddenly after breakfast</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) (State)	
21d. Time (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H. W. Ward</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/20/57</u>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF: <u>Nov. 21/57</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Elmonds Church</u>		LOCATION (City, town, or county) (State): <u>Chesapeake Beach, Md.</u>	
DATE REC'D BY LOCAL REG. <u>11-21-57</u>		REGISTRAR'S SIGNATURE: <u>H. W. Ward</u>		24. FUNERAL DIRECTOR: <u>Greg Berry</u>		ADDRESS: <u>Huntington, Md.</u>	

235 380365

RECEIVED

NOV 22 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10635 **CERTIFICATE OF DEATH**

10641

Reg. Dist. No.51

Item 9, Film G190 12-13-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Huntingtown</u>		<u>57</u>		Huntingtown		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>64 Prince Frederick</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Alice</u> <u>Coates</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11</u> <u>26</u> <u>1955</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 9, 1898</u>	9. AGE last birthday <u>56</u> <u>47</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Calvert County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joe Chase</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Husband</u> <u>Charles Coates, Huntingtown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>- Diabetes mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Amputation both legs (Two years ago).</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 26, 1955</u> to <u>Nov 26, 1955</u> , that I last saw the deceased alive on <u>Nov 26, 1955</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>R. E. Sewell</u> M.D.				ADDRESS (Street, city, town, state) <u>Prince Fred.</u> DATE SIGNED <u>Nov 27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>11-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Patuxent</u>		LOCATION (City, town, or county) (State) <u>Huntingtown Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>P. E. Sewell, Prince Fred.</u>			
DATE <u>11-29-55</u>							

1955 CERTIFICATE OF DEATH

1955

1. USUAL RESIDENCE (HOUSE OR ROOMING PLACE)

2. PLACE OF DEATH

3. MANNER OF DEATH

4. CAUSE OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. SEX

8. AGE

9. RACE

10. OCCUPATION

11. MARITAL STATUS

12. PLACE OF BIRTH

13. MEDICAL HISTORY

14. PRESENT ILLNESS

BUREAU V. 3

DEC 1 1955

RECEIVED

ENCLOSURE

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during the last illness. It should be filled out as soon as possible after death, and should be signed by the attending physician or other qualified person. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10636 **CERTIFICATE OF DEATH**

10642

Reg. Dist. No. 52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Prince Fred.</u>		LENGTH OF STAY (in this place) <u>40 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chesapeake Beach</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Allan</u>		(Middle) <u>T</u>		(Last) <u>Garland</u>		(Month) <u>Nov.</u> (Day) <u>30</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>January 29, 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - R. R. Dining Car Steward</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>New Found land</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Eli Garland</u>				14. MOTHER'S MAIDEN NAME <u>Sara Cummins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MRS. OLIVE Garland</u> <u>Chesapeake Beach, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
7824 IMMEDIATE CAUSE (A) <u>MALNUTRITION -</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>INTESTINAL RESECTION</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT 19 55</u> , to <u>NOV 30 55</u> , that I last saw the deceased alive on <u>NOV 30 55</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. C. Williams</u>				ADDRESS (Street, city, town, state) <u>St. Bernard</u>		DATE SIGNED <u>Nov 30</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Grace L. Hutchins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harry Fulchur</u>		ADDRESS <u>Wing</u>	
DATE <u>12/2/55</u>							

BUREAU V. 3

DEC 4 1965

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10637 CERTIFICATE OF DEATH

10643

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Calvert</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Prince Frederick</i>				TOWN <i>Olivet</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert County Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Gross</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Nov 3 19 55</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>—</i>	8. DATE OF BIRTH <i>December 3/1951</i>	9. AGE last birthday yrs. <i>4</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <i>7</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Bozell Gross Jr.</i>				14. MOTHER'S MAIDEN NAME <i>Norma Gray</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Norma Gray - Olivet</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
776X IMMEDIATE CAUSE (A) <i>Premature</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/3</i>, 19<i>55</i>, to <i>11/3</i>, 19<i>55</i>, that I last saw the deceased alive on <i>11/3</i>, 19<i>55</i>, and that death occurred at <i>1:30</i> M., from the causes and on the date stated above.							
SIGNATURE <i>Paul Lane</i> M.D.				ADDRESS (Street, city, town, state) <i>5th Avenue</i> DATE SIGNED <i>11/3</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <i>11-4-55</i>		NAME OF CEMETERY OR CREMATORY <i>Eastern Chapel</i>		LOCATION (City, town, or county) (State) <i>Olivet Md</i>	
24. REC'D BY REGISTRAR <i>11-4-55</i>		REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell</i> ADDRESS <i>Prince Frederick</i>			

20X5338232

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10638

CERTIFICATE OF DEATH

10644

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CALVERT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>CALVERT</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> TOWN <u>DARES BEACH</u>		<u>7 YRS.</u>		<u>DARES BEACH.</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>—</u>				<u>—</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>EMMA G. RUSHING</u>				<u>Nov. 9, 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>		8. DATE OF BIRTH <u>FEB. 3, 1876</u>	
9. AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months <u>9</u> Days <u>6</u>		Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HUMPHREYS CO., TENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FELIX TOTTY</u>				14. MOTHER'S MAIDEN NAME <u>NARCISSUS C. TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>DARES BEACH</u>	
				<u>KATHERINE PETERSON</u>		<u>MD</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>—</u>							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertrophic Arteriosclerosis Deformans</u>						6 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not while el work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1957</u> , to <u>11/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 28</u> , 19 <u>55</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. Prince Frederick</u>		DATE SIGNED <u>11/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>Nov. 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>APPOMATTOX CEM.</u>		LOCATION (City, town, or county) <u>HOPEWELL VA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>N. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. HARKNESS + SON</u>		ADDRESS <u>MUTUAL, MD.</u>	
DATE <u>11-10-55</u>							

ON 14-1955

RECEIVED

10639

10645
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 51

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Calvert</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Island Creek</u>	LENGTH OF STAY (in this place) <u>7 mos. 30 da.</u>	TOWN <u>Island Creek</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
		<u>md.</u>	

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Lanchester Roosevelt Thomas</u>		<u>November 6, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>male</u>	<u>colored</u>		<u>Mar. 7, 1955</u>
9. AGE last birthday: IF UNDER 1 YEAR		IF UNDER 24 HRS.	
yrs. <u>7</u> mos. <u>30</u> Days		Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
<u>NONE</u>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Calvert Co. Mosp.</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>ROBERT THOMAS</u>		<u>ERNESTINE SMITH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
<u>NO</u>			
17. INFORMANT & ADDRESS:			
<u>ERNESTINE SMITH</u>		<u>Island Creek Maryland</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
490X Immediate cause (a) <u>Solar Pneumonia</u> DUE TO		<u>2 days</u>
Antecedent cause(s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c) <u></u>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Dead without medical attn.</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
		<u>Island Creek Calvert</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>H. W. Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/6/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	

23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 8, 1955</u>		<u>St. Hope Church Cemetery</u>		<u>Sunderland Md.</u>	
DATE REC'D BY LOCAL REG. <u>11-7-55</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		24. FUNERAL DIRECTOR <u>LeRoy Berry</u>		ADDRESS <u>Huntingtown, Md.</u>	

2035151306

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

10039

10039

RECEIVED
BUREAU V. S.

BUREAU V. S.

RECEIVED

NOV 21 1955